PASRR FAQ
Training Date June 7, 2016

1. On the bottom of p. 39 of the PASRR updated manual, #7 states: plan regular meetings with the PASRR Coordinator. Could you please clarify what this entails? Someone within your agency should have the title as PASRR Coordinator. For some agencies this person is the PASRR Coordinator for both evaluations and specialized services (SS), for other agencies there is a coordinator for each. The PASRR SS case manager should be meeting with the PASRR Coordinator to keep them apprised of how everything is going with each individual receiving SS.
   (i.e. could you please define PASRR Coordinator: is the Caseworker/Specialized Services coordinator supposed to meet regularly with the Evaluator? No
   Who should be setting up these meetings, and how often should they occur? It is up to the PASSR Coordinator and Case Manager(s) to ensure that they meet as frequent as needed to ensure services are provided in a way that best meets the needs of the individual and problems are addressed timely.
   In our case, there is a two hour drive between the Evaluator and the SSC, so are phone conversations adequate? Yes

2. If using a Personal Service Agency certified by OIG, would we need to obtain a copy of the agency's certification for inclusion in the participant's chart? You are responsible for ensuring that the PSA is certified in accordance with 906 KAR 1:180.

3. Based on your examples, the goal should be met in 1 month. Is that really realistic and person centered for the person? The examples provided in the power point and during the webinar were just examples. You will need to base your timeframes on the individual you are serving. You may start with three month timeframes and once work starts with the individual realize that they are going to move much faster or slower and alter the timeframes.

4. Based on examples as well, it doesn't appear that working with clients for multiple years would be applicable. Can you clarify? With PASRR Specialized Services you work with an individual as long as they are interested and are benefitting from the service. Once a goal is met, then another goal can be added to the plan or multiple sequential goals can be on a plan to work on as the previous one has been met. You can continue to build on the skills that are learned to add new goals and skills. Also, ADL skills are something a nursing home should be working on, yet we are told not to duplicate what the nursing facility should be doing? The nursing facility provides rehabilitative services. PASRR Specialized Services provides habilitative services based on the individuals disability and functioning level.

5. Can you also clarify, you indicate that we can work on socialization yet Benita has indicated we should not be recommending Specialized Services for socialization? Some examples are included below (but not limited to these), of potential socialization goals that may be appropriate for specialized services that are habilitative in nature:
   Learning appropriate body space, how to greet people – shaking hands, making eye contact, saying hello - when/how to touch or not touch another person, learning the capacity to participate in a game with others, activities designed at seeking out friends, maintaining friendships/relationships, how much information to share with others, how to avoid being taken

advantage of, how to enter a group discussion, resolving conflict, saying no to unwanted requests, asking for what you want, etc.

6. Do you have a templated treatment plan that shows the different modalities of treatment we can view/be sent? I am not aware of a template treatment plan that shows the different modalities of treatment. If you want to see Active Treatment, you can ask to tour your closest ICF/IID center or SCL provider that provides Active Treatment. Each person's active treatment regimine will be specific to her/him, and no two person's plans are going to look the same, as they will have different levels of strengths/capacity as well as need/desires/goals.

7. Are there any double billing issues to be aware of if the client is going to day treatment from a SNF facility? There are no double billing issues. PASRR Specialized Services are paid for with State General Funds, not Medicaid or Medicare. They are also services that are not a part of what the nursing facility is required to provide. Ensure that Day Training services provided as an individual's specialized service is coded to PASRR Specialized Services and not to Day Training.

8. There are several different evaluation tools available that measures ADL's and socialization progress. Is there any you can recommend or would it be appropriate to list that as a goal to score a certain score on this tool by certain date? Any tool that measures progress on the goals and objectives would be acceptable, there is not a requirement for a formal tool as long as progress is measurable and included in the notes.

9. We have not seen the RAI, could we just see it? The RAI is an instrument that the nursing facility uses. One can be viewed at the nursing home or in a patient's chart.

10. I believe we should use empirical data to monitor progress instead of subjective observational data. Data is important when monitoring progress and we want the goals to be measurable but observations are important as well.

11. What is the computer summary sheet for discontinuation of services? The Computer Summary form captures information we are required by Medicaid to track for each individual/ Evaluation/ consultation. The Evaluator Coordinator/staff submit this when the final disposition of each evaluation occurs, meaning placement , discharge, beginning or ending specioalized services etc. When submitted accurately and consistently, we can see a detailed history of an individuals placements and health changes.

12. Are there any suggestions on how to formulate goals for individuals that are nonverbal and with significant physical impairments? Everyone has a skill that they could benefit from learning to help in being more independent or benefit from sensory stimulation to assist them in being more alert and aware of their surroundings that could lead to other goals to learn a skill. It needs to be based on the individual and what their strengths and needs are. Communication goals are usually helpful for some individuals who do not use words to communicate, or who are nonverbal. How does the person express choice, communicate feelings, desires, likes/wants/needs? How does the person explore likes/dislikes and communicate those? Can they use a pointer with their mouth? Do they have the adaptive equipment needed to function to their potential at being as independent as possible?

13. Are there any suggestions for how PASRR evaluation to offer suggestions for specialized services and be detailed enough for the services to be recommended without really knowing the individual? The new Level two evaluation form that is used for all PASRR evaluations relies on the evaluator to ask follow up questions when needed. It also containes a section added specifically for assiting in developing person centered plans and recommendations for the individual. Spending a short bit of time with the individual and or their family or even long-term caregivers, an evaluator should be able to ask what things are important to this person to achieve or maintain the ability to do. (Include only what the person says , have said, or indicated, with their words or behaviors, those things they consider essential to a comfortable and satisfying life.) When determining what may be important for the individual you would consider those things you have to keep in mind regarding health, safety, and prevention of regression, or loss of skills, which would become a barrier to community based services.

14. Will the power point be made available again? Yes, within 14 business days after today's webinar.

15. Can SS be provided at the NF & community settings, or only community settings? Specialized Services can be provided in both the nursing facility and in the community. A person may have multiple goals on their plan and one require that services be provided in the nursing facility and one that would require services in the community.

16. Can we please get a copy of the power point and all questions and answers? Yes, within 14 business days after today's webinar.

17. So could we contract with a PSA (a la CDO services through waiver) to provide Specialized Services to focus on habilitative tasks in the NF such as building communication skills, increasing independence with ADLs, etc...? Personal Service Agencies are agencies certified through OIG. That is an option, if contracting with a certified PSA or licensed ADHC, the SCL training and background check requirements are not required as OIG has regulatory requirements for the agencies they certify and license which must be followed.